

***Limited Data Set (LDS) for Hospital Outpatient Prospective Payment System (OPPS)  
Description, Fields, and Definitions***

***FILE DESCRIPTION***

This file contains select claim level data and is derived from 2005 hospital outpatient PPS claims, updated through December 2005, that is, claims for services furnished on or after January 1, 2005 through December 31, 2005 that were received, processed, paid, and passed to the National Claims History file by December 31, 2005. This file includes more than 54 million claims, for services paid under the OPPS, including observation, multiple and single claims. This is a flat file available on cartridges. The record length is 8419, blocksize is 32760.

Requests for clarification of file description, layout, and definitions only can be accepted at (410) 786-0378.

***FILE FIELDS***

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- PUBLIC USE FILE RECORD FORMAT

**01 PUF-DATA.**

10 PUF-TYPE	PIC X(4).
10 PUF-PROVIDER-NUMBER	PIC X(6).
10 FROM-DATE	PIC S9(5) COMP-3.
10 SERVICE-LINE-COUNT	PIC S9(3) COMP-3.
10 SERVICE-LINE-GROUP.	
15 SERVICE-LINE	
OCCURS 0 TO 300 TIMES	
DEPENDING ON SERVICE-LINE-COUNT.	
25 SERVICE-REVENUE-CODE	PIC X(4).
25 SERVICE-HCPCS	PIC X(5).
25 SERVICE-MJMC	PIC X.
25 SERVICE-DATE-OFFSET	PIC S9(3) COMP-3.
25 SERVICE-UNIT-COUNT	PIC S9(7) COMP-3.
25 SERVICE-TOTAL-CHARGES	PIC S9(9)V99 COMP-3.
25 SERVICE-COST	PIC S9(9)V99 COMP-3.

***CLAIM AND SERVICE LINE FIELD DEFINITIONS:***

***CLAIM FIELD DEFINITIONS***

Please note that CMS has revised the logic that we used to determine what is considered to be a major procedure versus a minor procedure. We refer readers to the narrative claims accounting document, which can be found on the OPPS Website, in order to understand the methodology employed.

TYPE: The claim type is either multi-major (MMAJ), multi-minor (MMIN), single major (SMAJ), single minor (SMIN), or observation (OBSV). These claim types are defined as:

**MULTI-MAJOR:** Claims with more than one separately payable procedure and/or multiple units of “major” procedures, (n=24,713,294). (These are examined carefully in stage 3 for dates of service and content to see if they can be divided into simulated or “pseudo” single claims.)

**MULTI-MINOR:** Claims with multiple HCPCS, multiple services on the same date of service, and/or that have multiple units of one or more procedure codes with status indicator N, (n = 44,858).

**SINGLE MAJOR:** Claims with a single unit of one separately payable procedure (SI= S, T, V or X, which are called “major” procedures), all of which will be used in median setting, (n=29,684,668).

**SINGLE MINOR:** Claims with a single unit of a single HCPCS to which we assigned the status indicator of N (packaged item or service) (n=40,111). We retain this file as insurance against last minute changes in packaging decisions

**OBSERVATION:** Claims with HCPCS G0244 billed

**PROVIDER-NUMBER:** The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

**FROM-DATE:** The date of service in quarter/year format

**SERVICE-LINE-COUNT:** The number of revenue codes appearing on the claim.

***SERVICE LINE FIELD DEFINITIONS***

**SERVICE-REVENUE-CODE:** The provider-assigned revenue code for each cost center for which a separate charge is billed. A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Revenue center code “0001” is used to identify the claim “totals” line.

**EXCEPTION:** Revenue center code 0001 represents the total of all revenue centers included on the claim.

**SERVICE-HCPCS:** Healthcare Common Procedure Coding System (HCPCS) code for an item or service, is a collection of codes that represent procedures.

**SERVICE-MJMC:** Each HCPCS code has an indicator for one of the following three classifications: J = major; M= minor; B = bypass. This indicator is used to sort the claims into the following groups: single majors, multiple majors, single minors, multiple minors, and non-OPPS claims.

**SERVICE-DATE-OFFSET:** the number of days from the actual claim date of service. The actual claim date of service is not provided except in quarter/year format, and can be found in the "FROM-DATE" field. This "SERVICE-DATE-OFFSET" field can be used to determine when line items were provided in comparison to other line items on the claim. The value "-999" will be used to indicate that the original line date of service was missing from the data.

**SERVICE-UNIT-COUNT:** The number of units of the item or service delivered.

**SERVICE-TOTAL-CHARGES:** The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.

**SERVICE-COST:** The charges adjusted to cost using the hospital's specific cost center cost-to-charge ratio